



March 28, 2003

ENGROSSED HOUSE BILL No. 1749

DIGEST OF HB 1749 (Updated March 26, 2003 2:52 PM - DI 104)

Citations Affected: IC 2-5; IC 12-15; IC 27-8; noncode.

Synopsis: Health insurance. Amends the comprehensive health insurance association (ICHIA) law concerning eligibility, prescription drug coverage, pharmacy and chronic disease management programs, out of pocket expenses, and termination of coverage. Specifies certain requirements that must be contained in another state's law concerning association group accident and sickness insurance policies if a policy issued in the other state covers an Indiana resident. Makes conforming and technical amendments.

Effective: July 1, 2003.

Fry, Ripley

(SENATE SPONSORS — MILLER, LANANE, PAUL)

January 21, 2003, read first time and referred to Committee on Insurance, Corporations and Small Business.

February 20, 2003, amended, reported — Do Pass.

February 26, 2003, read second time, amended, ordered engrossed.

February 27, 2003, engrossed. Read third time, passed. Yeas 90, nays 0.

SENATE ACTION

March 4, 2003, read first time and referred to Committee on Health and Provider Services.

March 27, 2003, amended, reported favorably — Do Pass.

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EH 1749—LS 6720/DI 97+



March 28, 2003

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

ENGROSSED HOUSE BILL No. 1749

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

- 1 SECTION 1. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS
2 [EFFECTIVE JULY 1, 2003]: Sec. 8. Beginning May 1, 1997, the
3 health policy advisory committee is established. At the request of the
4 chairman, the health policy advisory committee shall provide
5 information and otherwise assist the commission to perform the duties
6 of the commission under this chapter. The health policy advisory
7 committee members are ex officio and may not vote. The health policy
8 advisory committee members shall be appointed from the general
9 public and must include one (1) individual who represents each of the
10 following:
11 (1) The interests of public hospitals.
12 (2) The interests of community mental health centers.
13 (3) The interests of community health centers.
14 (4) The interests of the long term care industry.
15 (5) The interests of health care professionals licensed under
16 IC 25, but not licensed under IC 25-22.5.
17 (6) The interests of rural hospitals. An individual appointed under

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1 this subdivision must be licensed under IC 25-22.5.

2 (7) The interests of health maintenance organizations (as defined
3 in IC 27-13-1-19).

4 (8) The interests of for-profit health care facilities (as defined in
5 ~~IC 27-8-10-1(1)~~; **IC 27-8-10-1**).

6 (9) A statewide consumer organization.

7 (10) A statewide senior citizen organization.

8 (11) A statewide organization representing people with
9 disabilities.

10 (12) Organized labor.

11 (13) The interests of businesses that purchase health insurance
12 policies.

13 (14) The interests of businesses that provide employee welfare
14 benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

15 (15) A minority community.

16 (16) The uninsured. An individual appointed under this
17 subdivision must be and must have been chronically uninsured.

18 (17) An individual who is not associated with any organization,
19 business, or profession represented in this subsection other than
20 as a consumer.

21 SECTION 2. IC 12-15-35-28, AS AMENDED BY P.L.107-2002,
22 SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
23 JULY 1, 2003]: Sec. 28. (a) The board has the following duties:

24 (1) The adoption of rules to carry out this chapter, in accordance
25 with the provisions of IC 4-22-2 and subject to any office
26 approval that is required by the federal Omnibus Budget
27 Reconciliation Act of 1990 under Public Law 101-508 and its
28 implementing regulations.

29 (2) The implementation of a Medicaid retrospective and
30 prospective DUR program as outlined in this chapter, including
31 the approval of software programs to be used by the pharmacist
32 for prospective DUR and recommendations concerning the
33 provisions of the contractual agreement between the state and any
34 other entity that will be processing and reviewing Medicaid drug
35 claims and profiles for the DUR program under this chapter.

36 (3) The development and application of the predetermined criteria
37 and standards for appropriate prescribing to be used in
38 retrospective and prospective DUR to ensure that such criteria
39 and standards for appropriate prescribing are based on the
40 compendia and developed with professional input with provisions
41 for timely revisions and assessments as necessary.

42 (4) The development, selection, application, and assessment of

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interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.

(5) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year.

(6) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:

(A) The Indiana board of pharmacy.

(B) The medical licensing board of Indiana.

(C) The SURS staff.

(7) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.

(8) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.

(B) Potential or actual severe or adverse reactions to drugs.

(C) Therapeutic appropriateness.

(D) Overutilization or underutilization.

(E) Appropriate use of generic drugs.

(F) Therapeutic duplication.

(G) Drug-disease contraindications.

(H) Drug-drug interactions.

(I) Incorrect drug dosage and duration of drug treatment.

(J) Drug allergy interactions.

(K) Clinical abuse and misuse.

(9) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.

(10) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 483.60.

(11) The research, development, and approval of a preferred drug

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list for:

- (A) Medicaid's fee for service program;
- (B) Medicaid's primary care case management program; and
- (C) the primary care case management component of the children's health insurance program under IC 12-17.6;

in consultation with the therapeutics committee.

(12) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(13) The preparation and submission of a report concerning the preferred drug list at least two (2) times per year to the select joint commission on Medicaid oversight established by IC 2-5-26-3.

(14) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.

(15) Advising the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 concerning implementation of chronic disease management and pharmaceutical management programs under IC 27-8-10-3.5.

(b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.

(c) In researching and developing a preferred drug list under subsection (a)(11), the board shall do the following:

- (1) Use literature abstracting technology.
- (2) Use commonly accepted guidance principles of disease management.
- (3) Develop therapeutic classifications for the preferred drug list.
- (4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.
- (5) Include in any cost effectiveness considerations the cost implications of other components of the state's Medicaid program and other state funded programs.

(d) Prior authorization is required for coverage under a program described in subsection (a)(11) of a drug that is not included on the preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an

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1 additional sixty (60) days to make a determination from the date that
 2 the board receives adequate information to perform the board's review.
 3 Prior authorization may not be automatically required for a single
 4 source drug that is newly approved by the federal Food and Drug
 5 Administration and that is:

6 (1) in a therapeutic classification:

7 (A) that has not been reviewed by the board; and

8 (B) for which prior authorization is not required; or

9 (2) the sole drug in a new therapeutic classification that has not
 10 been reviewed by the board.

11 (f) The board may not exclude a drug from the preferred drug list
 12 based solely on price.

13 (g) The following requirements apply to a preferred drug list
 14 developed under subsection (a)(11):

15 (1) The office or the board may require prior authorization for a
 16 drug that is included on the preferred drug list under the following
 17 circumstances:

18 (A) To override a prospective drug utilization review alert.

19 (B) To permit reimbursement for a medically necessary brand
 20 name drug that is subject to generic substitution under
 21 IC 16-42-22-10.

22 (C) To prevent fraud, abuse, waste, overutilization, or
 23 inappropriate utilization.

24 (D) To permit implementation of a disease management
 25 program.

26 (E) To implement other initiatives permitted by state or federal
 27 law.

28 (2) All drugs described in IC 12-15-35.5-3(b) must be included on
 29 the preferred drug list.

30 (3) The office may add a new single source drug that has been
 31 approved by the federal Food and Drug Administration to the
 32 preferred drug list without prior approval from the board.

33 (4) The board may add a new single source drug that has been
 34 approved by the federal Food and Drug Administration to the
 35 preferred drug list.

36 (h) At least two (2) times each year, the board shall provide a report
 37 to the select joint commission on Medicaid oversight established by
 38 IC 2-5-26-3. The report must contain the following information:

39 (1) The cost of administering the preferred drug list.

40 (2) Any increase in Medicaid physician, laboratory, or hospital
 41 costs or in other state funded programs as a result of the preferred
 42 drug list.



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(3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.

(4) The number of times prior authorization was requested, and the number of times prior authorization was:

(A) approved; and

(B) disapproved.

(i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office.

SECTION 3. IC 27-8-5-16.5, AS AMENDED BY P.L.96-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;

(2) the delivery state has approved the group policy; and

(3) the policy or the certificate contains provisions that are:

(A) substantially similar to the provisions required by:

(i) section 19 of this chapter;

(ii) section 21 of this chapter; and

(iii) IC 27-8-5.6; and

(B) consistent with the requirements set forth in:

(i) section 24 of this chapter;

(ii) IC 27-8-6;

(iii) IC 27-8-14;

(iv) IC 27-8-23;

(v) 760 IAC 1-38.1; and

(vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter, **including the requirements that apply to association groups, particularly the requirement that the**

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association must be organized and maintained in good faith for purposes other than obtaining insurance;

(2) the delivery state has approved the group policy; and

(3) the policy or the certificate contains provisions that are:

(A) substantially similar to the provisions required by:

(i) section 19 of this chapter;

(ii) section 21 of this chapter; and

(iii) IC 27-8-5.6; and

(B) consistent with the requirements set forth in:

(i) section 15.6 of this chapter;

(ii) section 24 of this chapter;

(iii) section 26 of this chapter;

(iv) IC 27-8-6;

(v) IC 27-8-14;

(vi) IC 27-8-14.1;

(vii) IC 27-8-14.5;

(viii) IC 27-8-14.7;

(ix) IC 27-8-14.8;

(x) IC 27-8-20;

(xi) IC 27-8-23;

(xii) IC 27-8-24.3;

(xiii) IC 27-8-26;

(xiv) IC 27-8-28;

(xv) IC 27-8-29;

(xvi) 760 IAC 1-38.1; and

(xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.

SECTION 4. IC 27-8-10-1, AS AMENDED BY P.L.1-2001, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term

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1 does not include a Medicare supplement policy that is issued under
2 section 9 of this chapter.

3 (d) "Carrier" means an insurer providing medical, hospital, or
4 surgical expense incurred health insurance policies.

5 (e) "Church plan" means a plan defined in the federal Employee
6 Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

7 (f) "Commissioner" refers to the insurance commissioner.

8 (g) "Creditable coverage" has the meaning set forth in the federal
9 Health Insurance Portability and Accountability Act of 1996 (26 U.S.C.
10 9801(c)(1)).

11 (h) "Eligible expenses" means those charges for health care services
12 and articles provided for in section 3 of this chapter.

13 (i) "Federally eligible individual" means an individual:

14 (1) for whom, as of the date on which the individual seeks
15 coverage under this chapter, the aggregate period of creditable
16 coverage is at least eighteen (18) months and whose most recent
17 prior creditable coverage was under a:

18 (A) group health plan;

19 (B) governmental plan; or

20 (C) church plan;

21 or health insurance coverage in connection with any of these
22 plans;

23 (2) who is not eligible for coverage under:

24 (A) a group health plan;

25 (B) Part A or Part B of Title XVIII of the federal Social
26 Security Act; or

27 (C) a state plan under Title XIX of the federal Social Security
28 Act (or any successor program);

29 and does not have other health insurance coverage;

30 (3) with respect to whom the individual's most recent coverage
31 was not terminated for factors relating to nonpayment of
32 premiums or fraud;

33 (4) who, if after being offered the option of continuation coverage
34 under the Consolidated Omnibus Budget Reconciliation Act of
35 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state
36 program, elected such coverage; and

37 (5) who, if after electing continuation coverage described in
38 subdivision (4), has exhausted continuation coverage under the
39 provision or program.

40 (j) "Governmental plan" means a plan as defined under the federal
41 Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d))
42 and any plan established or maintained for its employees by the United

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1 States government or by any agency or instrumentality of the United
2 States government.

3 (k) "Group health plan" means an employee welfare benefit plan (as
4 defined in 29 U.S.C. 1167(1)) to the extent that the plan provides
5 medical care payments to, or on behalf of, employees or their
6 dependents, as defined under the terms of the plan, directly or through
7 insurance, reimbursement, or otherwise.

8 (l) "Health care facility" means any institution providing health care
9 services that is licensed in this state, including institutions engaged
10 principally in providing services for health maintenance organizations
11 or for the diagnosis or treatment of human disease, pain, injury,
12 deformity, or physical condition, including a general hospital, special
13 hospital, mental hospital, public health center, diagnostic center,
14 treatment center, rehabilitation center, extended care facility, skilled
15 nursing home, nursing home, intermediate care facility, tuberculosis
16 hospital, chronic disease hospital, maternity hospital, outpatient clinic,
17 home health care agency, bioanalytical laboratory, or central services
18 facility servicing one (1) or more such institutions.

19 (m) "Health care institutions" means skilled nursing facilities, home
20 health agencies, and hospitals.

21 (n) "Health care provider" means any physician, hospital,
22 pharmacist, or other person who is licensed in Indiana to furnish health
23 care services.

24 (o) "Health care services" means any services or products included
25 in the furnishing to any individual of medical care, dental care, or
26 hospitalization, or incident to the furnishing of such care or
27 hospitalization, as well as the furnishing to any person of any other
28 services or products for the purpose of preventing, alleviating, curing,
29 or healing human illness or injury.

30 (p) "Health insurance" means hospital, surgical, and medical
31 expense incurred policies, nonprofit service plan contracts, health
32 maintenance organizations, limited service health maintenance
33 organizations, and self-insured plans. However, the term "health
34 insurance" does not include short term travel accident policies,
35 accident only policies, fixed indemnity policies, automobile medical
36 payment, or incidental coverage issued with or as a supplement to
37 liability insurance.

38 (q) "Insured" means all individuals who are provided qualified
39 comprehensive health insurance coverage under an individual policy,
40 including all dependents and other insured persons, if any.

41 (r) "Medicaid" means medical assistance provided by the state under
42 the Medicaid program under IC 12-15.



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(s) "Medical care payment" means amounts paid for:

- (1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;
- (2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and
- (3) insurance covering medical care referred to in subdivisions (1) and (2).

(t) "Medically necessary" means health care services that the association has determined:

- (1) are recommended by a legally qualified physician;
- (2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and
- (3) are not primarily for the scholastic education or vocational training of the provider or patient.

(u) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(v) "Policy" means a contract, policy, or plan of health insurance.

(w) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(x) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(y) "**Resident**" means an individual who is:

- (1) legally domiciled in Indiana for at least one hundred eighty (180) days before applying for an association policy; or**
- (2) a federally eligible individual and legally domiciled in Indiana.**

(z) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

~~(z)~~ **(aa)** "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

~~(aa)~~ **(bb)** "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

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1 ~~(bb)~~ (cc) "Medicare supplement policy" means an individual policy
 2 of accident and sickness insurance that is designed primarily as a
 3 supplement to reimbursements under Medicare for the hospital,
 4 medical, and surgical expenses of individuals who are eligible for
 5 Medicare benefits.

6 ~~(cc)~~ (dd) "Limited service health maintenance organization" has the
 7 meaning set forth in IC 27-13-34-4.

8 SECTION 5. IC 27-8-10-2.1, AS AMENDED BY P.L.192-2002(ss),
 9 SECTION 169, IS AMENDED TO READ AS FOLLOWS
 10 [EFFECTIVE JULY 1, 2003]: Sec. 2.1. (a) There is established a
 11 nonprofit legal entity to be referred to as the Indiana comprehensive
 12 health insurance association, which must assure that health insurance
 13 is made available throughout the year to each eligible Indiana resident
 14 applying to the association for coverage. All carriers, health
 15 maintenance organizations, limited service health maintenance
 16 organizations, and self-insurers providing health insurance or health
 17 care services in Indiana must be members of the association. The
 18 association shall operate under a plan of operation established and
 19 approved under subsection (c) and shall exercise its powers through a
 20 board of directors established under this section.

21 (b) The board of directors of the association consists of seven (7)
 22 members whose principal residence is in Indiana selected as follows:

23 (1) Three (3) members to be appointed by the commissioner from
 24 the members of the association, one (1) of which must be a
 25 representative of a health maintenance organization.

26 (2) Two (2) members to be appointed by the commissioner shall
 27 be consumers representing policyholders.

28 (3) Two (2) members shall be the state budget director or
 29 designee and the commissioner of the department of insurance or
 30 designee.

31 The commissioner shall appoint the chairman of the board, and the
 32 board shall elect a secretary from its membership. The term of office
 33 of each appointed member is three (3) years, subject to eligibility for
 34 reappointment. Members of the board who are not state employees may
 35 be reimbursed from the association's funds for expenses incurred in
 36 attending meetings. The board shall meet at least semiannually, with
 37 the first meeting to be held not later than May 15 of each year.

38 (c) The association shall submit to the commissioner a plan of
 39 operation for the association and any amendments to the plan necessary
 40 or suitable to assure the fair, reasonable, and equitable administration
 41 of the association. The plan of operation becomes effective upon
 42 approval in writing by the commissioner consistent with the date on



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1 which the coverage under this chapter must be made available. The
 2 commissioner shall, after notice and hearing, approve the plan of
 3 operation if the plan is determined to be suitable to assure the fair,
 4 reasonable, and equitable administration of the association and
 5 provides for the sharing of association losses on an equitable,
 6 proportionate basis among the member carriers, health maintenance
 7 organizations, limited service health maintenance organizations, and
 8 self-insurers. If the association fails to submit a suitable plan of
 9 operation within one hundred eighty (180) days after the appointment
 10 of the board of directors, or at any time thereafter the association fails
 11 to submit suitable amendments to the plan, the commissioner shall
 12 adopt rules under IC 4-22-2 necessary or advisable to implement this
 13 section. These rules are effective until modified by the commissioner
 14 or superseded by a plan submitted by the association and approved by
 15 the commissioner. The plan of operation must:

- 16 (1) establish procedures for the handling and accounting of assets
 17 and money of the association;
- 18 (2) establish the amount and method of reimbursing members of
 19 the board;
- 20 (3) establish regular times and places for meetings of the board of
 21 directors;
- 22 (4) establish procedures for records to be kept of all financial
 23 transactions, and for the annual fiscal reporting to the
 24 commissioner;
- 25 (5) establish procedures whereby selections for the board of
 26 directors will be made and submitted to the commissioner for
 27 approval;
- 28 (6) contain additional provisions necessary or proper for the
 29 execution of the powers and duties of the association; and
- 30 (7) establish procedures for the periodic advertising of the general
 31 availability of the health insurance coverages from the
 32 association.

33 (d) The plan of operation may provide that any of the powers and
 34 duties of the association be delegated to a person who will perform
 35 functions similar to those of this association. A delegation under this
 36 section takes effect only with the approval of both the board of
 37 directors and the commissioner. The commissioner may not approve a
 38 delegation unless the protections afforded to the insured are
 39 substantially equivalent to or greater than those provided under this
 40 chapter.

41 (e) The association has the general powers and authority enumerated
 42 by this subsection in accordance with the plan of operation approved



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by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association. ~~and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.~~

(13) Provide for the use of managed care plans for insureds, including the use of:

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1 (A) health maintenance organizations; and

2 (B) preferred provider plans.

3 (14) Solicit bids directly from providers for coverage under this
4 chapter.

5 (f) Rates for coverages issued by the association may not be
6 unreasonable in relation to the benefits provided, the risk experience,
7 and the reasonable expenses of providing the coverage. Separate scales
8 of premium rates based on age apply for individual risks. Premium
9 rates must take into consideration the extra morbidity and
10 administration expenses, if any, for risks insured in the association. The
11 rates for a given classification may not be more than one hundred fifty
12 percent (150%) of the average premium rate for that class charged by
13 the five (5) carriers with the largest premium volume in the state during
14 the preceding calendar year. In determining the average rate of the five
15 (5) largest carriers, the rates charged by the carriers shall be actuarially
16 adjusted to determine the rate that would have been charged for
17 benefits identical to those issued by the association. All rates adopted
18 by the association must be submitted to the commissioner for approval.

19 (g) Following the close of the association's fiscal year, the
20 association shall determine the net premiums, the expenses of
21 administration, and the incurred losses for the year. Any net loss shall
22 be assessed by the association to all members in proportion to their
23 respective shares of total health insurance premiums, excluding
24 premiums for Medicaid contracts with the state of Indiana, received in
25 Indiana during the calendar year (or with paid losses in the year)
26 coinciding with or ending during the fiscal year of the association or
27 any other equitable basis as may be provided in the plan of operation.
28 For self-insurers, health maintenance organizations, and limited service
29 health maintenance organizations that are members of the association,
30 the proportionate share of losses must be determined through the
31 application of an equitable formula based upon claims paid, excluding
32 claims for Medicaid contracts with the state of Indiana, or the value of
33 services provided. In sharing losses, the association may abate or defer
34 in any part the assessment of a member, if, in the opinion of the board,
35 payment of the assessment would endanger the ability of the member
36 to fulfill its contractual obligations. The association may also provide
37 for interim assessments against members of the association if necessary
38 to assure the financial capability of the association to meet the incurred
39 or estimated claims expenses or operating expenses of the association
40 until the association's next fiscal year is completed. Net gains, if any,
41 must be held at interest to offset future losses or allocated to reduce
42 future premiums. Assessments must be determined by the board

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members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

~~(t)~~ The association shall pay an agent's referral fee of twenty-five dollars (\$25) to each insurance agent who refers an applicant to the association if that applicant is accepted:

~~(m)~~ (l) The association and the premium collected by the association shall be exempt from the premium tax, the adjusted gross income tax, or any combination of these upon revenues or income that may be imposed by the state.

~~(n)~~ (m) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

~~(o)~~ (n) The association shall provide for the option of monthly

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1 collection of premiums.

2 SECTION 6. IC 27-8-10-2.3, AS ADDED BY P.L.167-2002,
3 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
4 JULY 1, 2003]: Sec. 2.3. A member shall, not later than October 31 of
5 each year, certify an independently audited report to the:

- 6 (1) association;
- 7 (2) legislative council; and
- 8 (3) department of insurance;

9 of the amount of tax credits taken against assessments by the member
10 under section ~~2-1(n)(1)~~ **2.1(m)(1)** of this chapter during the previous
11 calendar year.

12 SECTION 7. IC 27-8-10-3.5 IS ADDED TO THE INDIANA CODE
13 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
14 1, 2003]: **Sec. 3.5. (a) The association shall:**

15 **(1) approve and implement chronic disease management and**
16 **pharmaceutical management programs based on:**

17 **(A) an analysis of the highest cost health care services**
18 **covered under association policies;**

19 **(B) a review of chronic disease management and**
20 **pharmaceutical management programs used in**
21 **populations similar to insureds; and**

22 **(C) a determination of the chronic disease management**
23 **and pharmaceutical management programs expected to**
24 **best improve health outcomes in a cost effective manner;**

25 **(2) consider recommendations of the drug utilization review**
26 **board established by IC 12-15-35-19 concerning chronic**
27 **disease management and pharmaceutical management**
28 **programs;**

29 **(3) when practicable, coordinate programs adopted under this**
30 **section with comparable programs implemented by the state;**
31 **and**

32 **(4) implement a copayment structure for prescription drugs**
33 **covered under an association policy.**

34 **(b) A program approved and implemented under this section**
35 **may not require prior authorization for a prescription drug that is**
36 **prescribed for the treatment of:**

37 **(1) human immunodeficiency virus (HIV) or acquired**
38 **immune deficiency syndrome (AIDS) and is included on the**
39 **AIDS drug assistance program formulary adopted by the**
40 **state department of health under the federal Ryan White**
41 **CARE Act (42 U.S.C. 300ff); or**

42 **(2) hemophilia according to recommendations of the:**

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(A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or

(B) Medical and Scientific Advisory Council of the National Hemophilia Foundation.

(c) The copayment structure implemented under subsection (a) must be based on an annual actuarial analysis.

(d) A disease management program for which federal funding is available is considered to be approved by the association under this section.

(e) An insured who has a chronic disease for which at least one (1) chronic disease management program is approved under this section shall participate in an approved chronic disease management program for the chronic disease as a condition of coverage of treatment for the chronic disease under an association policy.

SECTION 8. IC 27-8-10-3.6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 3.6. (a) The association shall approve a mail order or Internet based pharmacy (as defined in IC 25-26-18-1) through which an insured may obtain prescription drugs covered under an association policy.

(b) A prescription drug that is covered under an association policy is covered if the prescription drug is obtained from:

(1) a pharmacy approved under subsection (a); or

(2) a pharmacy that:

(A) is not approved under subsection (a); and

(B) agrees to sell the prescription drug at the same price as a pharmacy approved under subsection (a).

(c) A prescription drug that is:

(1) covered under an association policy; and

(2) obtained from a pharmacy not described in subsection (b); is covered for an amount equal to the price at which a pharmacy described in subsection (b) will sell the prescription drug, with the remainder of the charge for the prescription drug to be paid by the insured.

SECTION 9. IC 27-8-10-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in accordance with this chapter must impose a ~~five hundred dollar (\$500)~~ deductible on a per person per policy year basis **in an amount that is:**

(1) **equal to five hundred dollars (\$500) for a policy year**



beginning in 2003; and

(2) determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.

The deductible must be applied to the first five hundred dollars (\$500) of eligible expenses, other than prescription drug expenses, first incurred by the covered person during the policy year.

(b) Subject to the limitation provided in subsection (c), a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) of eligible expenses in excess of the mandatory deductible.

(c) The maximum aggregate out-of-pocket payments for eligible expenses, other than prescription drug expenses, by the insured in the form of deductibles and coinsurance may not exceed:

(1) one thousand five hundred dollars (\$1,500) per individual or two thousand five hundred dollars (\$2,500) per family, per policy year for a policy year beginning in 2003; and

(2) an amount that is determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.

SECTION 10. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 5.1. (a) Except as provided in subsections subsection (b), and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.



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For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(c) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to

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the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 11. IC 27-8-10-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 6. (a) An association policy offered under this chapter must contain provisions under which the association is obligated to renew the contract until:

(1) the date on which coverage terminates under section 5.1 of this chapter; or

(2) the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the

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1 younger spouse must be used as the basis for meeting the
 2 durational requirement of this ~~subsection~~ **subdivision**.

3 (b) The association may not change the rates for association policies
 4 or Medicare supplement policies except on a class basis with a clear
 5 disclosure in the policy of the association's right to do so.

6 (c) An association policy offered under this chapter must provide
 7 that upon the death of the individual in whose name the contract is
 8 issued, every other individual then covered under the contract may
 9 elect, within a period specified in the contract, to continue coverage
 10 under the same or a different contract until such time as he would have
 11 ceased to be entitled to coverage had the individual in whose name the
 12 contract was issued lived.

13 SECTION 12. IC 27-8-10-10 IS AMENDED TO READ AS
 14 FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 10. Before January 1,
 15 1996, the board of directors of the association shall establish eligibility
 16 guidelines for the issuance of an association policy under this chapter
 17 to prohibit an:

- 18 (1) employer;
- 19 (2) insurance ~~agent~~ **producer**; or
- 20 (3) insurance broker;

21 from placing in or referring to the association an individual who works
 22 for an employer who offers employees an employee welfare benefit
 23 plan (as defined in 29 U.S.C. 1002).

24 SECTION 13. [EFFECTIVE JULY 1, 2003] **IC 27-8-10-3.5 and**
 25 **IC 27-8-10-3.6, both as added by this act, and IC 27-8-10-4,**
 26 **IC 27-8-10-5.1, and IC 27-8-10-6, all as amended by this act, apply**
 27 **to an association policy that is issued, delivered, amended, or**
 28 **renewed after June 30, 2003.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1749, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete everything after the enacting clause, begin a new paragraph

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB1749 as introduced.)

FRY, Chair

Committee Vote: yeas 12, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1749 be amended to read as follows:

Page 2, between lines 20 and 21, begin a new paragraph and insert:
 "SECTION 2. IC 27-8-5-16.5, AS AMENDED BY P.L.96-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

- (1) the delivery state has a law substantially similar to section 16 of this chapter;
- (2) the delivery state has approved the group policy; and
- (3) the policy or the certificate contains provisions that are:
 - (A) substantially similar to the provisions required by:
 - (i) section 19 of this chapter;
 - (ii) section 21 of this chapter; and
 - (iii) IC 27-8-5.6; and
 - (B) consistent with the requirements set forth in:
 - (i) section 24 of this chapter;
 - (ii) IC 27-8-6;
 - (iii) IC 27-8-14;
 - (iv) IC 27-8-23;
 - (v) 760 IAC 1-38.1; and
 - (vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

- (1) the delivery state has a law substantially similar to section 16 of this chapter, **including the requirements that apply to association groups, particularly the requirement that the association must be organized and maintained in good faith for purposes other than obtaining insurance;**
- (2) the delivery state has approved the group policy; and
- (3) the policy or the certificate contains provisions that are:
 - (A) substantially similar to the provisions required by:

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- (i) section 19 of this chapter;
 - (ii) section 21 of this chapter; and
 - (iii) IC 27-8-5.6; and
- (B) consistent with the requirements set forth in:
- (i) section 15.6 of this chapter;
 - (ii) section 24 of this chapter;
 - (iii) section 26 of this chapter;
 - (iv) IC 27-8-6;
 - (v) IC 27-8-14;
 - (vi) IC 27-8-14.1;
 - (vii) IC 27-8-14.5;
 - (viii) IC 27-8-14.7;
 - (ix) IC 27-8-14.8;
 - (x) IC 27-8-20;
 - (xi) IC 27-8-23;
 - (xii) IC 27-8-24.3;
 - (xiii) IC 27-8-26;
 - (xiv) IC 27-8-28;
 - (xv) IC 27-8-29;
 - (xvi) 760 IAC 1-38.1; and
 - (xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance."

Page 9, line 12, after "association" delete ".".

Re-number all SECTIONS consecutively.

(Reference is to HB 1749 as printed February 21, 2003.)

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1749, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, between lines 20 and 21, begin a new paragraph and insert:
 "SECTION 2. IC 12-15-35-28, AS AMENDED BY P.L.107-2002, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 28. (a) The board has the following duties:

- (1) The adoption of rules to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any office approval that is required by the federal Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508 and its implementing regulations.
- (2) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.
- (3) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the compendia and developed with professional input with provisions for timely revisions and assessments as necessary.
- (4) The development, selection, application, and assessment of interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.
- (5) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year.
- (6) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:
 - (A) The Indiana board of pharmacy.
 - (B) The medical licensing board of Indiana.
 - (C) The SURS staff.
- (7) The establishment of a grievance and appeals process for

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physicians or pharmacists under this chapter.

(8) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

- (A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.
- (B) Potential or actual severe or adverse reactions to drugs.
- (C) Therapeutic appropriateness.
- (D) Overutilization or underutilization.
- (E) Appropriate use of generic drugs.
- (F) Therapeutic duplication.
- (G) Drug-disease contraindications.
- (H) Drug-drug interactions.
- (I) Incorrect drug dosage and duration of drug treatment.
- (J) Drug allergy interactions.
- (K) Clinical abuse and misuse.

(9) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.

(10) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 483.60.

(11) The research, development, and approval of a preferred drug list for:

- (A) Medicaid's fee for service program;
- (B) Medicaid's primary care case management program; and
- (C) the primary care case management component of the children's health insurance program under IC 12-17.6;

in consultation with the therapeutics committee.

(12) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(13) The preparation and submission of a report concerning the preferred drug list at least two (2) times per year to the select joint commission on Medicaid oversight established by IC 2-5-26-3.

(14) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder

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or attention deficit hyperactivity disorder.

(15) Advising the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 concerning implementation of chronic disease management and pharmaceutical management programs under IC 27-8-10-3.5.

(b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.

(c) In researching and developing a preferred drug list under subsection (a)(11), the board shall do the following:

- (1) Use literature abstracting technology.
- (2) Use commonly accepted guidance principles of disease management.
- (3) Develop therapeutic classifications for the preferred drug list.
- (4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.
- (5) Include in any cost effectiveness considerations the cost implications of other components of the state's Medicaid program and other state funded programs.

(d) Prior authorization is required for coverage under a program described in subsection (a)(11) of a drug that is not included on the preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration and that is:

- (1) in a therapeutic classification:
 - (A) that has not been reviewed by the board; and
 - (B) for which prior authorization is not required; or
- (2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

(f) The board may not exclude a drug from the preferred drug list based solely on price.

(g) The following requirements apply to a preferred drug list

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developed under subsection (a)(11):

(1) The office or the board may require prior authorization for a drug that is included on the preferred drug list under the following circumstances:

- (A) To override a prospective drug utilization review alert.
- (B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.
- (C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.
- (D) To permit implementation of a disease management program.
- (E) To implement other initiatives permitted by state or federal law.

(2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.

(3) The office may add a new single source drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.

(4) The board may add a new single source drug that has been approved by the federal Food and Drug Administration to the preferred drug list.

(h) At least two (2) times each year, the board shall provide a report to the select joint commission on Medicaid oversight established by IC 2-5-26-3. The report must contain the following information:

- (1) The cost of administering the preferred drug list.
- (2) Any increase in Medicaid physician, laboratory, or hospital costs or in other state funded programs as a result of the preferred drug list.
- (3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.
- (4) The number of times prior authorization was requested, and the number of times prior authorization was:
 - (A) approved; and
 - (B) disapproved.

(i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office."

Page 12, delete lines 23 through 42.

Delete pages 13 through 14.

Page 15, delete lines 1 through 17.

Page 15, line 21, delete "use the Medicaid preferred drug list

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developed under" and insert **"approve and implement chronic disease management and pharmaceutical management programs based on:**

- (A) an analysis of the highest cost health care services covered under association policies;**
- (B) a review of chronic disease management and pharmaceutical management programs used in populations similar to insureds; and**
- (C) a determination of the chronic disease management and pharmaceutical management programs expected to best improve health outcomes in a cost effective manner;**
- (2) consider recommendations of the drug utilization review board established by IC 12-15-35-19 concerning chronic disease management and pharmaceutical management programs;**
- (3) when practicable, coordinate programs adopted under this section with comparable programs implemented by the state; and**
- (4) implement a copayment structure for prescription drugs covered under an association policy.**

(b) A program approved and implemented under this section may not require prior authorization for a prescription drug that is prescribed for the treatment of:

- (1) human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and is included on the AIDS drug assistance program formulary adopted by the state department of health under the federal Ryan White CARE Act (42 U.S.C. 300ff); or**
- (2) hemophilia according to recommendations of the:**
 - (A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or**
 - (B) Medical and Scientific Advisory Council of the National Hemophilia Foundation."**

Page 15, delete lines 22 through 27.

Page 15, line 28, delete "(b)" and insert "(c)".

Page 15, delete lines 30 through 35.

Page 15, line 36, delete "(b)" and insert "(d)".

Page 15, line 39, delete "(c)" and insert "(e)".

Page 16, line 3, delete "IC 27-8-10-3.7" and insert "IC 27-8-10-3.6".

Page 16, line 5, delete "3.7." and insert "3.6".

Page 16, between lines 22 and 23, begin a new paragraph and insert:
"SECTION 10. IC 27-8-10-4 IS AMENDED TO READ AS

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FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in accordance with this chapter must impose a ~~five hundred dollar (\$500)~~ deductible on a per person per policy year basis **in an amount that is:**

(1) equal to five hundred dollars (\$500) for a policy year beginning in 2003; and

(2) determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.

The deductible must be applied to the ~~first five hundred dollars (\$500)~~ of eligible expenses, **other than prescription drug expenses, first** incurred by the covered person **during the policy year.**

(b) Subject to the limitation provided in subsection (c), a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) of eligible expenses in excess of the mandatory deductible.

(c) The maximum aggregate out-of-pocket payments for eligible expenses, **other than prescription drug expenses,** by the insured in the form of deductibles and coinsurance may not exceed:

(1) one thousand five hundred dollars (\$1,500) per individual or two thousand five hundred dollars (\$2,500) per family, per policy year for a policy year beginning in 2003; and

(2) an amount that is determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor."

Page 16, line 25, delete "A person is not eligible for an".

Page 16, delete line 26.

Page 16, line 27, delete "(b)".

Page 16, run in lines 25 through 27.

Page 16, line 27, strike "subsections" and insert "**subsection**".

Page 16, line 27, reset in roman "(b)".

Page 16, line 27, after "(b)" insert ",".

Page 16, line 27, delete "(c)".

Page 16, line 27, strike "and".

Page 16, line 27, delete "(d)".

Page 16, line 34, reset in roman "(b)".

Page 16, line 34, delete "(c)".

Page 16, line 34, after "IC 27-13-16-4" insert ",".

Page 16, line 34, delete "and subsection (a)".

Page 17, line 16, delete "(d)" and insert "(c)".

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Page 17, line 26, reset in roman "(d)".
 Page 17, line 26, delete "(e)".
 Page 17, line 42, reset in roman "(e)".
 Page 17, line 42, delete "(f)".
 Page 18, line 13, reset in roman "(f)".
 Page 18, line 13, delete "(g)".
 Page 18, line 13, reset in roman "(g)".
 Page 18, line 13, delete "(h)".
 Page 18, line 22, reset in roman "(g)".
 Page 18, line 22, delete "(h)".
 Page 18, line 25, reset in roman "(b)".
 Page 18, line 25 delete "(c)".
 Page 18, line 33, reset in roman "(h)".
 Page 18, line 33, delete "(i)".
 Page 19, line 27, delete "(a)".
 Page 19, line 27, delete "IC 27-8-10-3.5," and insert "**IC 27-8-10-3.5 and**".
 Page 19, line 28, delete "and IC 27-8-10-3.7, all" and insert "**both**".
 Page 19, delete lines 32 through 38.
 Renumber all SECTIONS consecutively.
 and when so amended that said bill do pass.
 (Reference is to HB 1749 as reprinted February 27, 2003.)
 MILLER, Chairperson
 Committee Vote: Yeas 9, Nays 0.

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